MAP 248
(Rev. 4/09)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
Home Health Program

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Agency Information

Agency Name: _____ Provider#: _____
Agency Address: _____

Recipient Information

Patient's Name: _____ Medicaid ID#: _____

Date of Birth: _____ Other Insurance: _____ Medicare HIC# _____
Address: _____
Diagnosis: _____

HCPCS Code	Item Description	Quantity/ Units	Start Date	End Date

This is to certify that the above medical supplies are essential to meet the medical needs of this recipient.

Anticipated Duration of Need: ☐ 0-30 days ☐ 1-3 months ☐ 4– 6 months

I, _____ certify this patient requires the supplies listed above.
(Physician's Name Printed)

_____ _____ _____ _____
Physician's Signature UPN # Date

Address: _____

Must be signed and dated by the physician every 6 months.